MDR Tracking Number: M5-04-0941-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 12-01-03.

The IRO reviewed outpatient services rendered on 06-25-03 that was denied based upon "V".

The Medical Review Division has reviewed the IRO decision and determined that the requestor **did not prevail** on the issues of medical necessity. Consequently, the requestor is not owed a refund of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 02-11-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
3-10-03 through 6-18-03 (4 DOS)	99213	$192.00 (1 unit @ $48.00 X 4 DOS)	$0.00	NO EOB	$48.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
4-10-03	99214	$71.00 (1 unit)	$0.00	NO EOB	$71.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Reference	Rationale
3-20-03 through 9-17-03 (3 DOS)	97032	$63.14 (DOS 3-20-03 billed @ $22.00	$0.00	NO EOB	DOS 3-20-03 $22.00	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.

		DOS 8-13-03 and 9-17-03 billed @ $20.57 X 2 DOS)			DOS 8-13-03 and 9-17-03 $18.83		
3-20-03 and 9-17-03 (2 DOS)	97018	$24.25 (DOS 3-20-03 billed @ $16.00 DOS 9-17-03 billed @ $8.25	$0.00	NO EOB	DOS 3-20-03 $16.00 DOS 9-17-03 $7.55	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
8-13-03	97016	$17.62 91 unit)	$0.00	NO EOB	$16.13	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
8-13-03 through 9-25-03 (3 DOS)	98940	$131.68 (1 unit @ $32.92 X 4 DOS)	$0.00	NO EOB	$25.69	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
9-17-03	97035	$15.32 91 unit)	$0.00	NO EOB	$14.22	Rule 133.307 (g)(3)(A-F)	Requestor did not submit relevant information to support delivery of service. No reimbursement recommended.
TOTAL		$515.01	$0.00				The requestor is not entitled to any reimbursement.

This Findings and Decision is hereby issued this 21st day of April 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

DLH/dlh

NOTICE OF INDEPENDENT REVIEW DECISION

Date: February 6, 2004

MDR Tracking #: M5-04-0941-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic physician reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
According to the supplied documentation, it appears that the claimant sustained a fracture to her left tibia while falling down at work on ___. The claimant reported to a chiropractor 2 days later for treatment. The claimant apparently underwent chiropractic treatment. The notes supplied were for dates of service 03/10/2003, 03/20/2003, 03/27/2003, 04/10/2003, 06/18/2003, 06/25/2003, 08/13/2003, 09/17/2003, 09/22/2003 and 09/25/2003. There was also a 3-page letter from the treating physician about medical necessity. The documentation ends here.

Requested Service(s)
Please review and address the medical necessity of the outpatient services rendered on 06/25/2003.

Decision
I agree with the insurance company that the services rendered were not medically necessary.

Rationale/Basis for Decision
The documentation provided was limited. The claimant sustained a fracture to her left lower extremity on ___. There were no additional studies supplied supporting any other diagnosis besides the fracture. The fracture should have healed in approximately 6-8 weeks with no additional complications. The date of service in question was an office visit ___ post-injury. There was not any adequate objective documentation that would support continued evaluations at the time in question. The 06/25/2003 daily note stated the claimant had muscle strength of 2/5 in her lower left leg. According to ___.In Physical Examination and Health Assessment, on page 679, a grade 2 is considered "full range of motion with gravity eliminated." The documentation did not provide any rationale that would explain how the claimant was at 2/5-muscle strength, some ___ post-injury. If the claimant were truly at a 2/5, it would

significantly inhibit her ability to walk at all. If the claimant were able to walk in to the treating doctor's facility, then she would not be considered a grade 2. There was not any documentation that supported a severe muscle weakness in her left leg. The 06/25/2003 daily note also reported a diagnosis of internal derangement, but with no supporting diagnostics. Overall, the daily notes provided do not support the 06/25/2003 office visit as reasonable or medically necessary in this claimant's case.